

Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OCCUPATIONAL HISTORY

*Have you ever worked full time (30 hours per week or more) for six months or more? ☐ Yes | ☐ No

*Have you ever worked for a year or more in any dusty job? ☐ Yes | ☐ No | ☐ N/A

*Have you ever been exposed to gas or chemical fumes in your work? ☐ Yes | ☐ No

If so, specific job industry

Total years worked was exposure mild ☐ moderate ☐ severe ☐

What has been your usual job/occupation—the one you have worked at the longest?

Job/occupation

Number of years in this occupation

Position/job title

Business, field or industry

Review of Systems: Do you have an existing problem and/or recent problem with: (Please circle or check next to each)

GENERAL		LUNGS		BONES/JOINTS	
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Back Pain/Injury/Surgery
<input type="checkbox"/>	Fevers	<input type="checkbox"/>	Sputum	<input type="checkbox"/>	Pain
<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	Cough Up Blood	<input type="checkbox"/>	Stiffness
<input type="checkbox"/>	Chills or Fever	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Swelling
<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Tenderness
<input type="checkbox"/>	Swelling in Groin/Armpit	<input type="checkbox"/>	Neumoniam	<input type="checkbox"/>	Pain on Motion
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Limited Motion
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Emphysema	VASCULAR	
SKIN		HEART		<input type="checkbox"/>	Circulation Problems
<input type="checkbox"/>	Rashes	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Leg Cramps
<input type="checkbox"/>	Poor Healing	<input type="checkbox"/>	Shortness of Breath at Rest	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	Shortness of Breath on Exertion	<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	Changes in Lumps/Moles	<input type="checkbox"/>	Palpitations	NERVES	
EYES		<input type="checkbox"/>	Ankle swelling	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Blurring	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Pain	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	Cataracts	BREAST		<input type="checkbox"/>	Weakness
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	Dizziness

<input type="checkbox"/> Wear Glasses/Contacts	<input type="checkbox"/> Discharge	<input type="checkbox"/> Trouble Speaking
EARS	<input type="checkbox"/> Mammography	<input type="checkbox"/> Trouble Walking
<input type="checkbox"/> Wear Hearing Aid	ABDOMEN	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Ringing	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Depression
<input type="checkbox"/> Deafness/Trouble Hearing	<input type="checkbox"/> Change in Bowel Habits	<input type="checkbox"/> Difficulty Sleeping
<input type="checkbox"/> Infections	<input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Headaches
NOSE/SINUS	<input type="checkbox"/> Black Tarry Stools	WOMEN ONLY
<input type="checkbox"/> Infections	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Bleeding Between Periods
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Ulcer Disease	<input type="checkbox"/> Regular Monthly Periods
<input type="checkbox"/> Nasal Congestion w/o Cold	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Have You Ever taken Birth Control Pills?
THROAT	<input type="checkbox"/> Constipation	<input type="checkbox"/> DES Exposure
<input type="checkbox"/> Infections	<input type="checkbox"/> History of Jaundice	<input type="checkbox"/> Pap Test Within a Year
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Pain With Periods
<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/> Hernia	<input type="checkbox"/> Latest Menstrual Period Date:
ENDOCRINE	<input type="checkbox"/> Food Intolerance	<input type="checkbox"/> # Days Menstrual Flow
<input type="checkbox"/> Thyroid Problems	GENITOURINARY	<input type="checkbox"/> # Pregnancies
<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> Urgency	<input type="checkbox"/> # Abortions
<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Increased Frequency	<input type="checkbox"/> # Births
<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Burning	MEN ONLY
<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Discharge from Penis
ORAL	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Prostate Trouble
<input type="checkbox"/> Seen by Dentist Within Last Year	<input type="checkbox"/> Infections	<input type="checkbox"/> Dribbling
<input type="checkbox"/> Gums Bleed Easily		<input type="checkbox"/> Sexual Difficulty
<input type="checkbox"/> Teeth		

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